Conversations

FROM THE DOCTORS' DINING ROOM

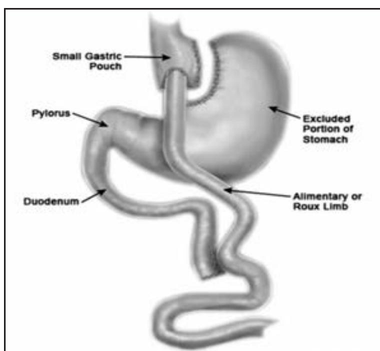
BETHESDA NORTH HOSPITAL APRIL 2012 • *Volume 4, Issue 1*

Surgical Options for Morbid Obesity

By Kevin Tymitz MD, General Surgeon

Obesity is a significant health concern in this country. It is a disease that is created by a multitude of genetic and environmental factors and affects 34 percent of adults age 20 and over in the United States. The consequences of obesity are as equally complex as its etiology, having effects on every organ system in the human body. There are well-established relations between excess body weight and serious medical conditions, such as type 2 diabetes, hypertension, and heart disease, just to name a few. Obesity also imposes serious psychological stress, often associated with social isolation, depression and numerous other psychological co-morbidities.

Unfortunately, there is no single solution to prevent or treat obesity that will be beneficial for everyone. Treatment of obesity may include a combination of diet, exercise, behavior modification and medications. For most patients, these methods may provide a moderate amount of weight loss, but the benefits are usually short lived. Hence, bariatric surgery has evolved over the past couple of decades and has been shown to be effective in reducing obesity-related co-morbidities, improving the quality of life, and decreasing the number of sick days, monthly medication costs and overall mortality. With the increasing rates of weight loss procedures, the quality, efficacy and surgical outcomes have improved with the creation of Bariatric Centers of Excellence, such as the Good Samaritan Center for Weight Management, designated by the American Society of Metabolic and Bariatric Surgery or American College of Surgeons. The benefits of bariatric procedures in morbidly obese patients outweigh the risks. With the advent of minimally invasive surgical procedures, bariatric surgery is a reasonable treatment option in those who strongly desire substantial weight loss and have life-threatening co-morbid conditions.



Roux-en-Y Gastric Bypass

Roux-en-Y Gastric Bypass

Roux-en-Y gastric bypass (RYGB) is the most common bariatric procedure performed in the United States (60 to 70 percent overall) and in my practice. It has been demonstrated in numerous reports to achieve durable long-term weight loss and remission of metabolic disease with a reasonably low complication rate. The remission of type 2 diabetes is amongst the highest of the bariatric procedures, with a rate of 84 to 98 percent, depending on the preoperative severity and duration. Interestingly, normoglycemia often occurs within days after the operation, well before significant weight loss has occurred. This suggests that the resolution of type 2 diabetes is related not only to restriction of caloric intake, but also to changes in gut peptide secretion secondary to bypassing a portion of the foregut. The exact mechanism by which this occurs remains to be elucidated, but is an area of ongoing research. The RYGB offers between 60 to 80 percent of excess body weight loss. However, given that a portion of

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From the Editor

LETTING GO OF THE PAST

The world was a different place in the early eighties when I returned to Cincinnati after completing residency and fellowship training. Looking back, it seemed a much simpler time. I opened a small office down the street from Bethesda Oak Hospital, just across from the Vernon Manor, and hung up a solo practice shingle, like a gunslinger staking out his territory at the end of the bar at the local saloon. In many ways, the private practice of medicine was reminiscent of frontier life. You set up your own homestead and relied on your neighboring docs for help and referrals. It was a time when physician/hospital alignment meant keeping in touch at medical staff meetings or over donuts in the physician lounge. We fought disease one patient at a time and were paid fairly well each time we did it, regardless of the outcome. The country's spending on health care was just 7.2 percent of the gross domestic product (GDP), about $75 billion, or $356 per U.S. resident, and we boasted of having the best system in the world. It was a time of plenty and no one was keeping score.

Fast forwarding to current times, neither Bethesda Oak Hospital nor the Vernon Manor Hotel exists today; in 2009, U.S. health care spending was 17.6 percent of GDP ($2.5 trillion) or about $8,160 per U.S. resident. With current trends, by 2018 spending will reach 20.3 percent of GDP ($4.3 trillion), with a medical bill of $13,100 for each person in the country. The United States ranks number one in health care spending as a share of GDP, with the number two slot falling to Switzerland at a distant 11.3 percent of GDP. With these large costs, we have purchased a health system which delivers a life expectancy that ranks

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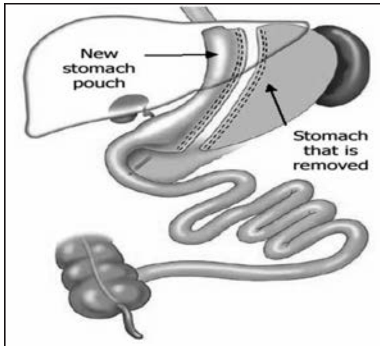
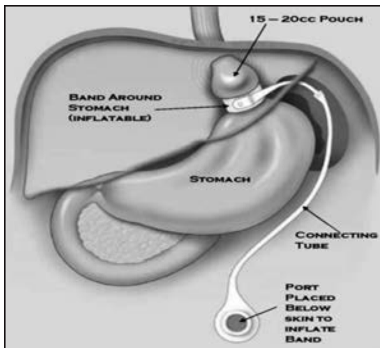
the small intestine is bypassed, patients are subject to nutritional deficiencies if supplementation is not maintained. Anastomotic leak is also a potential complication of RYGB. In experienced hands, however, the leak rate is less than 0.5 percent.



Vertical Sleeve Gastrectomy

Sleeve Gastrectomy

Of the commonly performed bariatric procedures, the laparoscopic vertical sleeve gastrectomy (LVSG) is the most recent to be introduced. Originally designed as a two-stage procedure for the super-morbidly obese, it has seen recent growth in popularity because of the simplicity of the surgical technique, resolution of co-morbidities, and excellent weight loss outcomes. Unlike the gastric band, the LVSG does not involve an implanted foreign body that can potentially erode or migrate, and it does not require frequent adjustments. Along with restriction, the sleeve resection may also achieve weight loss by impacting satiety. Serum levels of ghrelin, a pro-appetite hormone produced in the fundus, are reduced after the LVSG because that area of the stomach has been resected. The sleeve procedure is not reversible, because a partial gastrectomy is performed; but it can be converted to a gastric bypass or duodenal switch later if greater weight loss is desired. There is potential for a leak from the gastric staple line (approximately 1 percent). Patients can expect to lose approximately 40 to 60 percent of their excess body weight.



Laparoscopic Adjustable Gastric Band

Gastric Band

The laparoscopic adjustable gastric band (LAGB) received Food and Drug Administration approval in 2002 and has been in clinical use in the United States since then. It is a purely restrictive procedure, designed to make patients feel full early after a meal. It is the only device that is adjustable after surgery, allowing for tightening or loosening of the band via a subcutaneous port placed for fluid injection. Other advantages of the band include relative ease of placement; lack of operative staple lines or need for bowel transection; no malabsorption of vitamins or nutrients; and reversibility. The band does require, however, an average of one follow-up visit monthly for the first year for adjustments. Therefore, patients who are afraid of needles are not good candidates for a band. Also, there is a re-intervention rate of 40 to 50 percent with the band, because it is a foreign object against native tissue. There is a 6 percent chance that the band will erode into the stomach and around a 10 percent chance of a band slippage. Patients can expect to lose on average 30 to 50 percent of their excess body weight. For these reasons, along with a very high weight loss failure rate, the lap band is the least-performed procedure in my practice.

In conclusion, there are several different options for the surgical management of morbid obesity, each with different risks and benefits. It is important for patients and caregivers to know about the options in order to make an informed decision. Regardless, weight loss surgery is not a simple "cure" for this very complex and debilitating disease. It does, however provide a powerful tool for patients to achieve success. A successful long-term outcome is dependent on the patient's commitment to a lifetime of dietary and lifestyle changes regardless of the procedure performed. For this reason, there must be a multidisciplinary approach that includes surgeons, primary care physicians, psychologists, nurses and dieticians to provide critical instructions to help patients adhere to the dietary and lifestyle changes consistent with the surgery that they choose.

Contact Kevin Tymitz MD, Good Samaritan Weight Management Center, 3219 Clifton Ave., Suite 225, **513-862-4957**, or **Kevin_Tymitz@TriHealth.com**.
For information on the Good Samaritan Weight Management Center, visit ChangeForALifetime.com.

Physician Communications in Transition

In response to feedback from both employed and independent physicians within the TriHealth system, new communications channels created specifically for physicians will be rolling out in Fall 2012. A web-based portal will be a hub for physicians to access system resources and information. A quarterly physician magazine will be focused on higher-level clinical issues, research and hot topics in medicine.

Since the new magazine has many purposes similar to this newsletter, "Conversations from the Doctors' Dining Room" will no longer be published. Enjoy reading this final issue, and look for input from Bob Collins and other Bethesda North physicians in the new magazine.

Conversation with Stuart Donovan MD, Medical/Dental Staff President

Stuart Donovan MD, general surgeon with Queen City Surgical Consultants, began a two-year term as Medical/Dental Staff president in January 2012. He has been on Bethesda North's staff since 1991. Dr. Donovan also serves as Bethesda North site director for the Good Samaritan Surgical Residency Program. He shares his thoughts and plans for the Medical/Dental Staff in the next two years.

Q. What is your role as president of the Bethesda North TriHealth Hospital Medical/Dental Staff?

A. My role is to unify the medical staff, give them a voice and a vehicle to deal with medical staff issues, provide a forum and governance body, and support doctors through changes like the transition to Epic. People are very unsure about the future of medicine, and I'd like to be a conduit for concerns between physicians and administration.

Q. What are your priorities as Medical/Dental Staff president for 2012-2013?

A. Bringing electronic medical records into Bethesda North is the first priority and will bring a big change in how we conduct our day-to-day business. Having been through it in my own practice, I can see the difficulties and the great advantages. I think what will make it easier for all of us is to take the training seriously and really use the opportunity to formulate our own templates and personalize our order sets. We're still trying to identify super users to help us implement the new system. If you are interested, contact Dr. Mike Bain at 513-865-1307.

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Heart and Cancer Institutes Rely on New Level of Involvement from Physicians

"The Heart and Cancer institutes represent a fundamental shift in how we deliver medicine. We are aligning physicians with hospitals so everyone is functioning in the patient's best interest. The doctors responsible for delivering the care are now part of creating the structures. It's an entirely different perspective for doctors and is moving us toward a better balance of patient needs and economics." ~Bob Collins MD, FACS, vice president of Medical Affairs, Bethesda North TriHealth Hospital

The TriHealth Institute model features specialized, patient-centered care that gives physicians a larger role in creating the care continuum. Best practices and research are shared across a broader clinical audience, resulting in the most current, evidence-based methods for fighting disease. Patients benefit from improved access to care closer to home with the addition of more satellite locations for testing and treatment. TriHealth initially is focused on cancer and heart diseases and will add other institutes as opportunities arise.

TriHealth Cancer Institute

"Our unified and coordinated cancer care program takes care of patients from diagnosis through survivorship," explains Jose Barreau MD, TriHealth Cancer Institute physician leader. "Physicians help improve care by attending tumor boards and multidisciplinary clinics, giving patients automatic second opinions, while also providing a venue for physicians to work closely with colleagues to share ideas and best practices." The Mary Jo Cropper Center for Breast Care is the multidisciplinary model for cancer diagnoses.

With the implementation of TriHealth Connect in the coming months, TriHealth also will be better able to measure quality and outcomes in specific patient groups by accessing and analyzing electronic medical records.

The TriHealth Cancer Institute includes employed physicians from Oncology Partners Network and independent cancer specialists. A joint venture between TriHealth and

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LETTING GO OF THE PAST *continued from page 1*

number 26th of the most economically developed countries in the world, with one half of our adult population having at least one of the six leading chronic illnesses that plague humankind.

We have the world's most costly system, which delivers embarrassingly poor results in managing the health of our population. After years of tinkering at the design margins in our approaches to health care, it has become painfully obvious that small individual actions will never be an adequate response to the national health care crisis, but rather bold new approaches are needed.

Traditionally, hospitals have provided the facilities, equipment and support personnel, while the physician independently provided and prescribed the treatment and service options to patients. The visual picture of medical care from each of these perspectives yields a distorted view of the health care delivery system, which will not allow hospitals or practicing physicians to clearly identify successful solutions to manage the health of our community. We should all be encouraged by TriHealth taking a long-range, broad systematic approach and developing a true partnership with physicians as with the TriHealth Physician Institute and other meaningful alignment relationships. The insights gained from these relationships will be the corrective lenses which will allow us to clearly identify and create bold new solutions to improving clinical outcomes and controlling the cost of health care.

Your comments are welcomed. Send them to me at **Bob_Collins@TriHealth.com**.

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Bethesda North Hospital

Conversation with Stuart Donovan MD *(continued from page 3)*

Beyond integrating Epic into inpatient hospital work, I want to concentrate on re-invigorating and strengthening the medical staff as an entity. I have seen an erosion of the medical staff in the last several years, with the migration of primary care physicians away from the hospital setting. I'd like this body to be cohesive and to help with physician concerns.

Q. What is the value of the Medical/Dental Staff?
A. First, it's a great forum to disseminate information from physician to physician and hospital to medical staff. Enhanced communication improves quality and outcomes. We provide a bridge for physician specialties and newly formed institutes. Second, the Medical/Dental Staff offers a forum for physicians to tackle issues and problems. It also provides conferences and other opportunities for physician education.

As physicians move toward employment or affiliation with health organizations, there's a danger that the medical staff as an independent body will lose its relevance. I feel strongly, however, that we need a medical staff with its own identity and independent governance. Successful organizations realize it's in their best interest to have strong physician leadership.

I want to be available and responsive to doctors on our staff. Feel free to contact me at **513-232-8181**, **513-607-7418** (cell) or **stuart_donovan@trihealth.com**.

Heart and Cancer Institutes *(continued from page 3)*

Vantage Oncology to manage the Cancer Institute's radiation oncology services provides more locations for outpatient radiation oncology services.

TriHealth Heart Institute
The TriHealth Heart Institute recently grew stronger with the employment of heart specialists and the addition of outpatient cardiology testing centers. The Cardiology Center of Cincinnati joined TriHealth in July 2011 and Cardiology Associates of Cincinnati joined in October 2011.

"Pooling the resources of physicians and TriHealth hospitals will facilitate quality improvement initiatives, communication between providers, enhanced research opportunities and an overall more effective cardiovascular care team within TriHealth," notes Craig Sukin MD, FACC, TriHealth Heart Institute physician co-leader. "Patients will benefit from greater coordination and standardization of care as well as from the use of a common electronic medical record."

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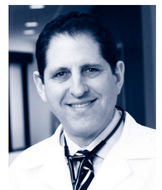
Craig Sukin MD

Save the date: Medical/Dental Staff Fall Social, Friday, Nov. 16, 2012, Bell Event Centre